ADHD Stimulants

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Please select the requested stimulant exception category (check all that apply):

☐ Age Limit
☐ Use of three (3) or more Stimulants
☐ Concurrent use of both methylphenidate and amphetamine drug class

Age Limit Exceeded, Criteria for Approval: *(Under 4 Years of Age **or** 6 years for Adzenys ER, Dyanavel XR, Desoxyn, Adhansia, Jornay PM, Cotempla XR)*

- ❑ Diagnosis made by or in consultation with children psychiatrist or mental health specialist who is qualified in the diagnosis and treatment of neuropsychiatric disease (certified, licensed scope of practice, etc.) with prescribing authority.
- ❑ Clinical rationale for ADHD stimulant use under Medicaid's age limit: _____
  _____Chart Note Page #: _____

Use of three (3) or more ADHD Stimulants, Criteria for Approval: *(For all ages. Not required for combinations of the same product that differ only by strength.)*

- ❑ Clinical rationale for using multiple stimulant agents: _____
  _____Chart Note Page #: _____

Concurrent use of both amphetamine and methylphenidate drug classes, Criteria for Approval: *(For those under 18 years.)*

- ❑ Clinical rationale for concurrent use of both methylphenidate and amphetamine drug classes: _____
  _____Chart Note Page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred product in same class, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product. Details: _____ Chart Note Page #: _____

Note:

- ❖ Medicaid strongly encourages prescribers to follow the American Academy of Pediatrics (AAP) recommendation in using evidence-based Parent Training in Behavior Management (PTBM) and/or behavioral classroom inventions as first-line therapy, if available.

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date